FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Dr. (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618) 233-7750 **Fax #** (618) 257-6839

IDPA ID Number: 37-0635502-002

Date of Initial License for Current Owners: 03/01/64

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Eleanor Benton Telephone Number: (618) 257-5603

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date) 04/19/2001

(Type or Print Name) Mary Ann Hagler

(Title) Administrative Assistant & Director of Nursing

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,384		22,051	26,435	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,384		22,051	26,435	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.88%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/03/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 108 and days of care provided 8496

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	348,320	2,400		350,720		350,720	312,439	663,159			1
2	Food Purchase		258,534		258,534		258,534	0	258,534			2
3	Housekeeping	119,091	10,591	1,238	130,920		130,920	34,406	165,326			3
4	Laundry		76,403		76,403		76,403	37,188	113,591			4
5	Heat and Other Utilities			77,305	77,305		77,305	0	77,305			5
6	Maintenance	41,729	23,628		65,357		65,357	880	66,237			6
7	Other (specify):*							0				7
8	TOTAL General Services	509,140	371,556	78,543	959,239		959,239	384,913	1,344,152			8
	B. Health Care and Programs											
9	Medical Director					11,629	11,629	0	11,629			9
10	Nursing and Medical Records	1,907,253	90,484	31,895	2,029,632	94	2,029,726	42,404	2,072,130			10
10a	Therapy	507,455	21,571		529,026		529,026	241,746	770,772			10a
11	Activities	67,468	1,348		68,816		68,816	0	68,816			11
12	Social Services	51,314			51,314		51,314	54,065	105,379			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):* Disp diapers		61,586		61,586		61,586	(25,463)	36,123			15
16	TOTAL Health Care and Programs	2,533,490	174,989	31,895	2,740,374	11,723	2,752,097	312,752	3,064,849			16
	C. General Administration											
17	Administrative	70,717			70,717	(11,629)	59,088	0	59,088			17
18	Directors Fees							0				18
19	Professional Services			10,567	10,567		10,567	0	10,567			19
20	Dues, Fees, Subscriptions & Promotions			4,045	4,045		4,045	0	4,045			20
21	Clerical & General Office Expenses	115,922		12,949	128,871	(1,121)	127,750	(51,631)	76,119			21
22	Employee Benefits & Payroll Taxes			630,107	630,107		630,107	13,450	643,557			22
23	Inservice Training & Education							0				23
24	Travel and Seminar							0				24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			46,727	46,727		46,727	0	46,727			26
27	Other (specify):* Bad Debts			55,824	55,824		55,824	(55,824)				27
28	TOTAL General Administration	186,639		760,219	946,858	(12,750)	934,108	(94,005)	840,103			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,229,269	546,545	870,657	4,646,471	(1,027)	4,645,444	603,660	5,249,104			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			106,720	106,720		106,720	134,747	241,467			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):* Loss on disposition			3,007	3,007		3,007	0	3,007			36
37	TOTAL Ownership			109,727	109,727		109,727	134,747	244,474			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers	75,790	218,109		293,899		293,899	143,467	437,366			39
40	Barber and Beauty Shops					1,027	1,027	0	1,027			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			59,292	59,292		59,292	0	59,292			42
43	Other (specify):*	59,550	50,194	8,428	118,172		118,172	57,588	175,760			43
44	TOTAL Special Cost Centers	135,340	268,303	67,720	471,363	1,027	472,390	201,055	673,445			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,364,609	814,848	1,048,104	5,227,561	0	5,227,561	939,462	6,167,023			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,370)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(892)	6		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,824)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,086)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,008,548		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,008,548		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 939,462		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		1,027	10	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,027		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS — Page 5A

Facility Name: Memorial Convalescent Center

ID#: 0003103

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	(892)
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	(892)
9	Non-Straightline Depreciation	(12,370)	30	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	(892)	6	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	0
22	Special Legal Fees & Legal Retainers	0	0	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	(55,824)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	0	0	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	(55,824)
29	Non-Paid Workers	0	0	Line 28	(55,824)
30	Donated Goods	0	0	Line 29	(56,716)
31	Amortization Expense	0	0	Line 30	(12,370)
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	(12,370)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(69,086)
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Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
15	17	18	19	20	21	22	23	24	25	26	27	30	31

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
32	33	34	35	36	38	39	40	41	42	43		

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	312,439	0	0	0	0	0	0	0	0	0	312,439	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	34,406	0	0	0	0	0	0	0	0	0	34,406	3
4	Laundry	0	37,188	0	0	0	0	0	0	0	0	0	37,188	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(892)	1,772	0	0	0	0	0	0	0	0	0	880	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(892)	385,805	0	0	0	0	0	0	0	0	0	384,913	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	42,404	0	0	0	0	0	0	0	0	0	42,404	10
10a	Therapy	0	241,746	0	0	0	0	0	0	0	0	0	241,746	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	54,065	0	0	0	0	0	0	0	0	0	54,065	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(25,463)	0	0	0	0	0	0	0	0	0	(25,463)	15
16	**TOTAL Health Care and Programs**	0	312,752	0	0	0	0	0	0	0	0	0	312,752	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(51,631)	0	0	0	0	0	0	0	0	0	(51,631)	21
22	Employee Benefits & Payroll Taxes	0	13,450	0	0	0	0	0	0	0	0	0	13,450	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(55,824)	0	0	0	0	0	0	0	0	0	0	(55,824)	27
28	**TOTAL General Administration**	(55,824)	(38,181)	0	0	0	0	0	0	0	0	0	(94,005)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,716)	660,376	0	0	0	0	0	0	0	0	0	603,660	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(12,370)	147,117	0	0	0	0	0	0	0	0	0	134,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,370)	147,117	0	0	0	0	0	0	0	0	0	134,747	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	143,467	0	0	0	0	0	0	0	0	0	143,467	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	57,588	0	0	0	0	0	0	0	0	0	57,588	43
44	**TOTAL Special Cost Centers**	0	201,055	0	0	0	0	0	0	0	0	0	201,055	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,086)	1,008,548	0	0	0	0	0	0	0	0	0	939,462	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Memorial Hospital	Belleville	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	22	Employee Benefits	$ 630,107	Memorial Hospital	0.00%	$ 643,557	$ 13,450	1	13450
2	V	21	Administration	127,750			76,119	(51,631)	2	-51631
3	V	6	Maintenance	142,662			144,434	1,772	3	1772
4	V	4	Laundry	76,403			113,591	37,188	4	37188
5	V	3	Housekeeping	130,920			165,326	34,406	5	34406
6	V	1	Dietary	350,720			663,159	312,439	6	312439
7	V	15	Central	61,586			36,123	(25,463)	7	-25463
8	V	39	Pharmacy,medical supplies	293,899			437,366	143,467	8	143467
9	V	43	Ancillary services	118,172			175,760	57,588	9	57588
10	V	12	Social service	51,314			105,379	54,065	10	54065
11	V	10	Medical records	1,121			43,525	42,404	11	42404
12	V	10a	Therapy	529,026			770,772	241,746	12	241746
13	V	30	Depreciation	106,720			253,837	147,117	13	147117
14	Total			$ 2,620,400			$ 3,628,948	$ * 1,008,548	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	Not Applicable										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Memorial Hospital
Street Address: 4500 Memorial Drive
City / State / Zip Code: Belleville,Il 62226
Phone Number: (618) 233-7750
Fax Number: (618) 257-6839

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Salaries	54,814,735	2	$ 16,370,747	$ 507,219	1,974,721	$ 589,762	1
2	21	Communications	Phones	940	2	551,805	171,206	6	3,522	2
3	21	Data Processing	Resources	10,024	2	1,459,943	640,983	110	16,021	3
4	21	Materials Mgt	Stores Requisitions	4,324,131	2	625,791	373,699	52,520	7,601	4
5	21	Administration	Accumulated Cost	114,243,787	2	6,917,038	2,756,730	2,797,894	169,402	5
6	6	Plant	Square Feet	18,453	1	165,348	41,729	16,119	144,434	6
7	4	Laundry	Pounds	2,508,076	2	911,330	337,604	312,614	113,591	7
8	3	Housekeeping MCC	Square Feet	17,705	1	181,593	119,091	16,119	165,326	8
9	1	Dietary	Patient Meals	264,548	2	3,074,261	1,600,026	79,314	921,693	9
10	22	Emp Benefits/Cafeteria	Employee Meals	127,554	2	1,020,952	368,559	6,721	53,795	10
11	10	Medical Records	Time Spent	10,000	2	2,560,312	1,394,464	170	43,525	11
12	12	Social Service	Time Spent	111,368	2	628,423	412,095	18,675	105,379	12
13	43	Radiology	Revenue	25,407,288	2	7,357,468	2,027,486	89,608	25,949	13
14	43	Laboratory	Revenue	41,590,087	2	9,997,213	3,139,323	374,534	90,029	14
15	43	Nutritional Support	Revenue	542,639	2	409,512	173,710	59,301	44,753	15
16	43	EKG	Revenue	11,982,469	2	2,482,633	855,947	72,539	15,029	16
17	39	Drugs & IV Therapy	Revenue	16,725,166	2	7,402,757	1,429,947	711,946	315,116	17
18	39	Medical Supplies Sold	Revenue	5,355,506	2	4,513,011	507,042	187,938	158,373	18
19	10a	Respiratory Care	Revenue	10,830,190	2	2,601,112	1,382,952	275,426	66,150	19
20	10a	Physical Therapy	Revenue	9,707,183	2	4,628,323	2,354,395	998,196	475,933	20
21	10a	Occupational Therapy	Revenue	1,092,941	2	401,638	251,004	580,910	213,475	21
22	10a	Speech Therapy	Revenue	106,462	2	93,935	52,386	17,243	15,214	22
23	30	Capital Cost	See Attached	12,573,766	2	12,573,766	0	253,837	253,837	23
24										24
25	TOTALS					$ 86,928,911	$ 20,897,597		$ 4,007,909	25

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2				NOT APPLICABLE								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995		8
	1996		9
	1997		10
	1998		11
	1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,365 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$ 10,521	33.3	$	$ (10,521)	$ 882,395	4
5			1966	1966	144,150	965	30.89		(965)	144,150	5
6			1979	1979	237,657	1,643	20.28	1,643		214,869	6
7			1980	1980	2,695					2,695	7
8			1981	1981	18,583					18,583	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Replace entrance doors			1997	3,410	114	15	227	113	795	9
10	Electrical Upgrade			1996	25,549	1,359	18.79	1,359		6,119	10
11	Walking track			1998	7,690	513	15	513		1,283	11
12	Roof replacement			1998	68,383	6,838	10	6,838		17,095	12
13	Change in electrical power system			1998	5,479	365	15	365		912	13
14	7 1/2 ton A/C unit			1998	14,326	955	15	955		2,388	14
15	Air furnace			1998	15,226	1,015	15	1,015		2,538	15
16	5 ton air handler			1998	14,900	993	15	993		2,483	16
17	Electrical work-boiler rm,A/Cunit,te;a,p,auto tr switch			1998	91,162	4,557	20	4,557		11,395	17
18	Air handling unit installed			1994	12,048	803	15	803		5,220	18
19	Repair parking lot			1994	83,569	7,702	10.85	7,702		50,058	19
20	Landscaping			1994	4,200	280	15	280		1,820	20
21	Flooring replaced in patient rooms			1993	56,883	3,792	15	3,792		28,440	21
22	Activity Therapy Renovation			1993	41,940	2,264	12.83	2,264		22,011	22
23	Condensing Unit			1993	4,684	312	15	312		2,340	23
24	Air conditioners			1993	6,589	439	15	439		3,293	24
25	Upgrade lighting			1993	4,516	226	20	226		1,695	25
26	Renovate patient rooms & nurse station			1992	42,370	2,321	17.99	2,321		20,059	26
27	Renovate patient rooms-doors,wallcovering,bldg.			1992	75,908	721	10.49	721		71,226	27
28	Roof top air conditioner			1992	4,342	289	15	289		2,461	28
29	Renovate business office			1991	35,387	1,911	18.5	1,911		20,060	29
30	Patient rooms-drywall,ceilings,paint			1991	39,835	2,426	14.55	2,426		26,002	30
31	Demolish back lounge			1991	752	50	15	50		475	31
32	Brickwork chimney			1991	5,225	348	15	348		3,306	32
33	Paint exterior tower			1991	1,185	0	5			1,185	33
34	ITE Panel			1991	995	50	20	50		475	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 53,772		$ 42,399	$ (11,373)	$ 1,567,826	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Air conditioner			1991	6,580	439	15	439		4,165	9
10	Telephone wiring			1991	924	93	10	93		875	10
11	Circuit breaker			1991	1,011	51	20	51		479	11
12	Cubicles & track			1990	9,899		5			9,899	12
13	Half glass door windows			1989	601	40	15	40		460	13
14	Roofing			1988	55,463		10			55,463	14
15	Air conditioner			1988	1,556		5			1,556	15
16	Air conditioner			1987	1,551		5			1,551	16
17	Remove bathroom showers			1987	17,966	484	15.56	484		14,926	17
18	Cooling units			1986	3,854		9			3,854	18
19	Cooling units			1985	5,644					5,644	19
20	Resurface road			1985	39,780					39,780	20
21	Guttering			1985	2,116	71	15	71		2,116	21
22	Metal door frames			1984	5,751	288	20	288		4,743	22
23	Water & sewer lines			1984	2,807	140	20	140		2,310	23
24	Sprinkle system			1978	27,578	1,103	25		(1,103)	27,578	24
25	Sprinkle system			1977	1,585		20			1,585	25
26	Cooling unit & heat detectors.			1974	5,468					5,468	26
27	Air conditioners & beauty shop			1973	1,210					1,210	27
28	Heating & cooling equipment			1972	53,944					53,944	28
29	Smoke detector			1971	5,800					5,800	29
30	Land Improvements			1968	4,238		40	106	106	3,551	30
31	Vinyl flooring rstrooms			1999	2,441	488	5	488		732	31
32	Reznor make up air unit			1999	15,432	1,543	10	1,543		2,315	32
33	Electrical work			1999	2,566	128	20	128		192	33
34	New door physical therapy			2000	3,735	125	15	125		125	34
35	Porch columns			2000	5,965	199	15	199		199	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 5,192		$ 4,195	$ (997)	$ 250,520	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 420,550	$ 41,051	$ 41,051	$	10.3	$ 297,905	37
38	Current Year Purchases	6,405	558	558		5.7	558	38
39	Fully Depreciated Assets	52,347					52,347	39
40								40
41	TOTALS	$ 479,302	$ 41,609	$ 41,609	$		$ 350,810	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		2000 Ford Bus	2000	$ 49,174	$ 6,147	$ 6,147	$	4	$ 6,147	42
43										43
44										44
45										45
46	TOTALS			$ 49,174	$ 6,147	$ 6,147	$		$ 6,147	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 106,720	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 94,350	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (12,370)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,175,303	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$ 23,946	$	$ 23,946	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 23,946	$	$ 23,946	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$ 185,438		$	$ 4,271		$ 189,709	1
2	Licensed Speech and Language Development Therapist		hrs	8,675			1,083		9,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	277,218			4,949		282,167	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts	75,790			218,109		293,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 547,121		$	$ 228,412		$ 775,533	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,587	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	533,339		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,875		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to third-party payors	(5,503)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 536,298	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,109,155		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	528,476		16
17	Accumulated Depreciation (book methods)	(2,133,660)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	152,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 696,260	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,232,558	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 94,257	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,149		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 200,406	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve for Self Insurance	274,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 274,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 474,406	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 758,152	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,232,558	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 786,470	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 786,470	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(68,498)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (68,498)	17
	B. Transfers (Itemize):		
18	**Interfund Transfer - Hospital**	40,180	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 40,180	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 758,152	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,432,295	1
2	Discounts and Allowances for all Levels	(1,643,176)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,789,119	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,596,349	6
7	Oxygen	275,426	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,871,775	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,027	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	711,946	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	374,534	19
20	Radiology and X-Ray	89,608	20
21	Other Medical Services	319,777	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,496,892	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	385	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 385	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Chapel Maintenance	892	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 892	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,159,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 959,239	31
32	Health Care	2,740,374	32
33	General Administration	946,858	33
	B. Capital Expense		
34	Ownership	109,727	34
	C. Ancillary Expense		
35	Special Cost Centers	293,899	35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37	Nutritional Support,Lab,X-ray,EKG	118,172	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,227,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	(68,498)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (68,498)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	508	569	$ 23,120	$ 40.63	1
2	Assistant Director of Nursing	1,797	2,136	51,750	24.23	2
3	Registered Nurses	28,352	30,301	660,864	21.81	3
4	Licensed Practical Nurses	6,584	7,122	103,144	14.48	4
5	Nurse Aides & Orderlies	71,864	76,927	806,071	10.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,310	5,633	67,468	11.98	10
11	Social Service Workers	2,831	3,065	51,314	16.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,114	40,073	348,320	8.69	15
16	Dishwashers					16
17	Maintenance Workers	3,425	3,768	41,729	11.07	17
18	Housekeepers	10,822	13,189	119,091	9.03	18
19	Laundry					19
20	Administrator	1,401	1,567	45,000	28.72	20
21	Assistant Administrator					21
22	Other Administrative	201	228	14,088	61.79	22
23	Office Manager					23
24	Clerical	24,625	27,205	377,105	13.86	24
25	Vocational Instruction	9,126	10,361	185,438	17.90	25
26	Academic Instruction					26
27	Medical Director	96	107	11,629	108.68	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	94	103	1,121	10.88	31
32	Other Health Care(specify)					32
33	Other(specify)	24,569	28,392	457,357	16.11	33
34	TOTAL (lines 1 - 33)	227,719	250,746	$ 3,364,609 *	$ 13.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	48	23,750		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Physician Advisor	63	7,200		46
47	Psychologist	15	1,450		47
48	Physician Reviewer	47	2,795		48
49	TOTAL (lines 35 - 48)	173	$ 35,195		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	7,037	105,406	Ln 10, col 1	52
53	TOTAL (lines 50 - 52)	7,037	$ 105,406		53

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ann Hagler	Admin. Assistant	0.00%	$ 45,000
Joe Lanius	V.P.-Finance	0.00%	5,722
Terry Walther	V.P/-Rehab	0.00%	8,366
Dr. William H. Sutherland	Medical Director	0.00%	11,629
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,717

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel J Mulvaney	Legal fees	$ 1,514
PricewaterhouseCoopers	Audit fees	4,740
AAA Credit	Collecion fees	4,313
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,567

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

* Attach copy of IMRF notifications

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care	4,045
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,045

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	NOT APPLICABLE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il. Health Care $4,045**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5.7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **36,123** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **59,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **53,795** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **932,013**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned for providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PricewaterhouseCoopers LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.